COUNTY OF LOS ANGELES – DEPARTMENT OF HEALTH SERVICES AFFIDAVIT OF RESIDENCY FOR PATIENTS PRESENTING AS HOMELESS

Patient:	Facility Nam	Facility Name:	
Medical Record No.:	Service Date	:	
Angeles County and do proof of my current add below is true and correct	nt of the County of Los Angeles. I into not maintain a home in another state, dress. I certify through my signature tet. I currently live at:	/country. I cannot provide that the statement given	
Contact for medical rea	sons:		
Address:			
Signature:P	Patient or Responsible Relative	Date	
	s statement and who willfully states as truect to the penalties prescribed for perjury of the W. & I. Code.		
Witness Signature	Telephone Number	Date	
(dichneonlate affidavit? doc)			

COUNTY OF LOS ANGELES – DEPARTMENT OF HEALTH SERVICES AFFIDAVIT OF RESIDENCY FOR PATIENTS PRESENTING AS HOMELESS

Patient:	Facility Na	nme:	
Medical Record No.:	Service Da	ite:	
I am a homeless resident of the County of Los Angeles. I intend to remain in Los Angeles County and do not maintain a home in another state/country. I cannot provide proof of my current address. I certify through my signature that the statement given below is true and correct. I currently live at:			
			
Contact for medical reasons:			
Address:			
Signature:Patient	or Responsible Relative	Date	
Any person who signs this statement and who willfully states as true any material matter which he knows to be false is subject to the penalties prescribed for perjury in the penal code by the State of California SEC 11054 of the W. & I. Code.			
Witness Signature	Telephone Number	Date	
(djohnson\atp affidavit2.doc)			